

Washington State Employee Assistance Program (EAP) Contracted Provider Invoice

Do not include any protected health information on this form. This is a billing form and the EAP referral number is required to receive reimbursement.

Provider's Name:

Make Check Payable To:

Mailing Address:

Phone Number:

Provider's EAP Contract Number:

EAP Referral Number (required):

Date of Service	Service Rendered	Time Spent

Provider Signature: _____ Credentials: _____ Date: _____

Submit this *invoice* along with all clinical forms to:

Department of Personnel
Employee Assistance Program
Attn: Contract Manager
1222 State Ave NE, Ste 201
Olympia, WA 98504
Toll-free: 877-313-4455
Direct: 360-753-3260
Fax: 360-664-0498

For internal use only

Fund _____ Program Index _____ Sub Object _____ Amount \$ _____ (Hours x \$60)

Signature Approval _____ Date _____



WSD Personnel Washington State
Employee
Assistance
Program

DOP 12-032 (4/22/08) EAP Contracted Provider Invoice